E. **Network Providers Billing with Multiple Tax Identification Numbers.**

Finding:

Numerous providers are billing with more than one federal tax identification number. The claims were paid as out of network claims (70% coinsurance percentage and no discount) because the tax identification number did not match the one provided to Acordia by KPHA or Dimension. According to Acordia Management, this is a common issue for all networks. Providers don't always notify the networks when their tax identification numbers change and it ultimately results in claims being paid out of network. A provider can only be matched to a specific network if they bill their claims with the tax identification number provided to Acordia by the network. KPHA plans to provide both social security numbers and tax identification numbers to Acordia to update their claim system for all KPHA providers.

The auditors also discovered many network providers have multiple suffixes added to their tax identification number. This can be a result of a change of address, data entry error or multiple locations and the provider may not be updated to the appropriate network. In addition, providers may be Group-Based and also provide services on an individual basis, therefore creating new suffixes and the potential of inaccurate processing.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.
3. Group Insurance Management should check the referral report on a monthly basis.

County Administrator's Response:

1. Group Insurance Management is aware that some providers bill under more than one federal tax identification number. This is done for a variety of reasons including their affiliation with other providers and location for providing the service. Some physicians are affiliated with a network in one location and not while practicing in another. When the provider supplies different federal tax identification numbers for these reasons, they can actually not be part of a network. Participants who believe they used a network doctor and were penalized for using a non-network provider should contact Acordia or the Group Insurance Office for assistance. Networks change on a frequent basis and it is the responsibility of the participant to verify network status before seeking treatment.
2. Group Insurance Management will establish guidelines to insure Acordia's listing of network providers is accurate and will utilize the services of the County's insurance consultant on a periodic basis to check the system.

F. Group Insurance Management Should Perform Regular Audits of Acordia Claims and Reports

Finding:

Group Insurance Management has been provided the ability to access Acordia's Host On Demand online claim system to allow audit and inquiries of claims. Numerous monthly reports from Acordia were provided to the auditors. The auditors reviewed the reports and found they had substantial benefits in identifying potential claim miscalculations. The following reports can provide Group Insurance Management information to monitor claims processed by Acordia:

1. Referral Report By Authorizing Provider - Monthly analysis of the report can quickly discover network providers paid as referrals and claims can be adjusted to properly reflect provider discounts.

2. Refund and Reversal Analysis - Monthly analysis of the report may help identify discounts rescinded and refunded to the provider. Timely review could provide the County the ability to document and correct discounts rescinded.

3. Single Payment Provider Listings - Monthly review may identify billed charges paid with an incorrect discount and can also provide claims to be selected for audit and inquiries.

4. Monroe County Employer Liaison Committee Agenda's - KPHA informs Group Insurance Management of provider additions and deletions. The changes need to be verified with Acordia to determine updates were completed accurately.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.

County Administrator's Response:

1. The above findings basically reflect a finding found throughout the audit. Management will be sure to develop ongoing monitoring and auditing ability so that these issues can be appropriately controlled.
2. Group Insurance Management is working with the consultant to establish a suitable method of audits and inquiries.
3. Group Insurance Management is concerned about proper listing of providers in the appropriate networks. However, the participant is the best source for insuring the proper accounting for network providers. The penalty for using an out-of-network provider is greater than many of our discounts. When an employee seeks medical treatment they should confirm that they are using a network provider. When

precertifications are done, KPHA informs the participant when they have selected an out-of-network provider and will offer in-network alternatives to the participant. Group Insurance Management will continue to work on the accuracy of the network providers with Acordia.

G. Group Insurance Management Should Provide Employee Education Regarding Health Care Claims

Finding:

Monroe County has established an employee benefit plan for the purpose of providing medical, prescription, dental, vision, utilization review and Cobra benefits for its employees. Increasing health care cost has forced the County to implement changes that will financially impact the employees, dependents and retirees with the intent of decreasing the cost of health care for the County. As of January 1, 2004, the benefit plan was modified and resulted in an increased cost of dependent coverage, increased coinsurance payments, increased prescription copayments and provided the employee the option of paying a premium for elective dental and vision coverage.

Employee participation is an integral part of controlling health care cost. With proper information and education employees will have the ability to assist in reducing the overall cost of benefits.

The direct impact of increasing health care cost and decreasing employee benefits has provided employees an increasing awareness in monitoring their own claims. For example, an employee brought to the attention of the auditors they had received a check from Acordia for services that had not been rendered. The provider was requesting preauthorization, but submitted the request on a claim form and a check was issued to the employee. The check was subsequently returned. In another instance, the employee had surgery and scrutinized the billing upon receipt. The employee discovered a charge of an additional hour of surgery time that was not performed. The employee has pursued the issue and the billing is being adjusted.

Recommendation(s):

1. Group Insurance Management should establish a regular program to educate employees on health care benefits and provide the information necessary to scrutinize claims to protect the employee and the County from overpayments.

County Administrator's Response:

1. Group Insurance Training is done at all New Employee Orientation with BOCC employees. All items that could cause discussion of the Group Insurance Program at a BOCC meeting are noticed to all active and retired participants in the insurance program. Changes to the Plan as adopted by the BOCC are noticed to all active and retired participants. In January 2002, Worker's Comp and Group began a county-wide program of training on those two programs. They were done in Plantation Key, Marathon, & Key West in January, February, March, April, June, and September, 2002 and January 2003. These training sessions were conducted with the various constitutional officers. Our Resource Link (newsletter for Board employees) notified employees that changes were to be voted on at the September 17, 2003 meeting of the BOCC and advising them that if they had not received the memo (that went to all employees and retirees) of the proposed

changes, to contact the Group Insurance Office for a copy. Open enrollment was held in November outlining all changes to the program. American General did presentations on November 20, 2003 in Key Largo and Marathon and on November 21, 2003 in Key West on the Dental and Vision Programs. Group Insurance Management works diligently to keep all employees informed of the program requirements. Group Insurance will establish a new set of orientation sessions for employees throughout the Keys.

VI. Exhibits

Exhibit A

Letter to Acordia
June 18, 2001

COUNTY of MONROE

BOARD OF COUNTY COMMISSIONERS
MAYOR George Neugent, District 2
Dixie M. Spehar, District 1
Charles "Sonny" McCoy, District 3
Mayor Pro Tem Nora Williams, District 4
Murray E. Nelson, District 5

Copy

Administrative Services Department
5100 College Road
Key West, FL 33040
(305) 292-4537

FAX MEMO
PAGES 2 DATE 3/11 FAX # 292-3681
TO SANDY MATHENA
FROM MONA FERNANDEZ
CC
PH # 292-4447 FAX #

Monday, June 18, 2001

Acordia National
602 Virginia Street, East
P. O. Box 3043
Charleston, WV 25331-3043

Attention: Richard H. Legg

Dear Mr. Legg:

On March 13, 2001, the Monroe County Board of County Commissioners passed some changes to the our health plan. The changes affecting processing our claims are:

Proposal Number 2 – Implementation of Emergency Room Visit deductible of $75 per visit. Implementation date is October 1, 2001.

Proposal Number 7 – Increase out of Network disincentive from 10% to 30%. This will be implemented when proposal Number 6 (securing network) is implemented.

Proposal Number 8 – Limit Chiropractic visits per calendar year from 60 to 30. Implement January 1, 2002.

Proposal Number 9 – Limit Massage Therapy visits per calendar year to 15. Implement January 1, 2002.

Proposal Number 10 – Limit Acupuncture Treatments per calendar year to 15. Implement January 1, 2002.

Proposal 11 – Vision Benefits – return to "no more than one complete visual examination, including refraction, during any two calendar years. Implement January 1, 2002.

MEMORANDUM

TO: Rick Legg
Lora Denny

FROM: Connie Raines

RE: County of Monroe plan changes

DATE: July 16, 2001

Questions on plan changes:

1) Proposal # 7 - increase out of Network disincentive from 10% to 30% - this will be implemented when proposal #6 (securing network - ???) is implemented.
   a) What is proposal 6?. I have no info on proposals 3 thru 6.
   b) When is proposal # 7 effective?

DISREGARD PROPOSAL #7

Questions on the **10/01/2001** plan changes:

1) Proposal # 2: ER deductible of $75. - does the $75. apply to the out of pocket? - **YES**
   a) Does the $75. deductible still apply once the out of pocket is met? – **YES, DEDUCTIBLE PER VISIT.**
   b) Once the $75. is taken, how are the balance of charges to be paid? – **80% IN-NETWORK; 70% OUT OF NETWORK.**
   c) Does the $75. deductible apply to both PPO & Non-PPO charges? - **YES**
   d) Does the $75. deductible apply to both medical emergencies & non-emergency treatment in the ER? – **YES, ONLY TIME DEDUCTIBLE IS WAIVE IS IF ER VISIT BECOME AN INPATIENT STAY.**
2) Proposal #14: What are the Medicare guidelines regarding unbundling of costs? Will these be manual for the examiner? Does anybody have this info? – **THIS RECOMMENDATION WAS MADE TO US BY KPHA AS A COST SAVINGS. THEY ARE CURRENTLY OBTAINING THIS INFORMATION. WE WILL FORWARD CRITERIA.**

Rick Legg

Lora Denny

Questions on the 01/01/2002 plan changes:

1) Proposal #9: What types of providers are covered to render massage therapy?
   a) Any guidelines for massage therapy (when or why it would be covered?)?
   PLEASE CHECK WITH LORA DENNY REGARDING HOW OUR PLAN CURRENTLY PROCESSES MASSAGE THERAPY CLAIMS. ONLY CHANGE TO PLAN IS LIMITATION OF VISITS TO 15 PER CALENDAR YEAR.
2) Proposal #11: Is there a dollar maximum for the eye exam? – **YES, $50.00 HAS ALWAYS BEEN THE DOLLAR MAXIMUM PAID UNDER OUR VISION PLAN FOR CORRECTION OF VISION.**
3) Proposal #13: Verify please: Individual out of pocket will be $2,200. plus deductible ($2,500. individual maximum - out of pocket plus deductible). – **CORRECT.**

Exhibit B

E-Mail from Acordia
August 26, 2003

Sandra Mathena

From: <Beverly_Burdette@AcordiaNational.com>
To: <smathena@monroe-clerk.com>
Cc: <Melanie_Slater@AcordiaNational.com>
Sent: Tuesday, August 26, 2003 3:57 PM
Subject: Monroe County Surgeries

Hey, I'm back and digging through my piles that accumulated while I was gone.

We need to discuss one of the requests you made while I was out. You asked me to "reprice" all surgery claims paid from Oct 1, 2001 through June 30, 2003. As you know, we have spent a tremendous amount of time reviewing all claim history for the past 3 years to assist you with your audit, and we are committed to doing everything possible to assist you and to fix any issues identified . However, you have asked me to tell you when your requests are unrealistic or not feasible . . . this request is not possible within any reasonable period of time. I'm not sure you understand what would be involved, but it is not something that can be done electronically or programmatically. Every claim over this period would have to be pulled and recalculated manually---we are talking hundreds of hours of review. My offer to set you up with a PC and system access here in WV is still open if you want to review all of these claims.

Further, I am concerned that the County is asking for surgery claims to be reviewed for this period when we have never received any written instructions to change our processing procedures. You and I have talked about this for at least 3-4 months, yet we have never received any written instructions to change our processing procedures, nor have we recieved any instructions to amend the plan. As of today, we are still not using Medicare's multiple surgery guidelines for processing surgery claims. If the County wants these changes made to the plan, they really need to notify us of this in writing.

Again, "unbundling" and "multiple surgeries" are two different issues.

Please review the fax you sent to me on August 8th. This memo is a list of questions we asked of Monroe County regarding their 10/1/2001 plan changes. In question number 2 we asked for clarification of what was meant by "Medicare guidelines of unbundling of costs" . The answer provided on this memo was, " THIS RECOMMENDATION WAS MADE TO US BY KPHA AS A COST SAVINGS. THEY ARE CURRENTLY OBTAINING THIS INFORMATION. WE WILL FORWARD CRITERIA." We have no record of receiving anything further from the County or KPHA.

Beverly Burdette
Vice President, Operations
Acordia National
Telephone: (304) 353-8781
Fax: (304) 353-8759

Exhibit C

Sample Letter from Fisherman's Hospital

Fishermen's HOSPITAL

June 19, 2002

Lois Wears
Acordia Insurance

VIA FAX: (304) 353-8773

RE: [redacted]

Dear Lois:

The KPHA contract allows for a twenty-five percent (25%) discount from the total charges on our claims. The contract states that the discount "will be rescinded if an appropriately documented and non-contested claim is not paid to the Participating Provider within thirty (30) days of being received by the claims administrator".

The above referenced claim was electronically transmitted by NEIC to you on 4/3/02. Partial payment on this claim was received on 5/21/02. We appealed the discount taken on that claim. The remainder of this payment was not received until 6/18/02 – seventy-seven (77) days after claim receipt. This discount is not valid either.

Please reprocess the ineligible discount taken of $8,642.25.

You can reach me at (305) 289-6425 should you have any questions. Thank you for your time.

Sincerely,

Gina L. Benjamin
Managed Care Coordinator

3301 Overseas Hwy.
Marathon, FL 33050
(305) 743-5533
Fax (305) 743-3962
www.fishermenshospital.com

Exhibit D

E-mail from KPHA

Barker-Sheila

From: LoweWatler, Meylan [Meylan.LoweWatler@lkmc.hma-corp.com]
Sent: Monday, January 12, 2004 4:21 PM
To: Barker-Sheila@MonroeCounty-FL.Gov; Fernandez-Maria@MonroeCounty-FL.Gov
Subject: Clean Claim, Notification of Claim Status, and Disputed Claims La nguage

Sheila:

I am providing some language that may be helpful in decreasing the confusion in claims processing with respect to the application of the discounts as follows:

Clean Claim
A "Clean Claim" means a claim submitted by the Provider/Hospital that has been properly and accurately completed on the appropriate paper or electronic claim form, HCFA 1500 and/or UB 92 together with any information that was requested in writing by Acordia National within 15 days of Acordia National's receipt of a claim.

Notification of Claim Status
Payor/Plan shall notify Provider/Hospital within 15 days of receipt of a claim that said claim is not considered "Clean" and reasons therefore. Failure to do so shall deem the claim being considered "Clean" and set for timely payment.

Disputed Claims
If the Payor/Plan does not object in writing to a claim within 15 days of receipt by the Payor/Plan, the claim will be considered clean and complete. If the Payor/Plan disputes any portion of the billing for services rendered, Payor/Plan will promptly seek to resolve the dispute and return the claim to the regular processing status. Should the claim remain in dispute for more than 30 days, Payor/Plan will pay the Provider/Hospital 90% of the fees as outlined in the "Provider Agreement Amendment/ Reimbursement Addendum" within 7 days with payment for the remaining 10% subject to the outcome of the dispute. Those items requiring further resolution prior to the remaining payment shall be reconciled by the Payor/Plan and the Provider/Hospital and the appropriate payments or adjustments made within 60 days.

Please let me know if I can add this language to our KPHA/MC Contract and I will also need to add the language as an addendum to the individual provider contracts. As soon as you let me know I can get the addendums which include the amended reimbursement amounts out to the providers.

Meylan Lowe-Watler
Assistant Administrator
Lower Keys Medical Center
5900 College Road
Key West, Florida 33040
305-294-5531, extension 3382

28/04

Exhibit E

Letter to Acordia
August 5, 2003

COUNTY of MONROE
KEY WEST FLORIDA 33040
(305) 294-4641

BOARD OF COUNTY COMMISSIONERS
Mayor Dixie M. Spehar, District 1
Mayor Pro Tem Murray E. Nelson, District 5
George Neugent, District 2
Charles "Sonny" McCoy, District 3
David P. Rice, District 4

County Administrator
1100 Simonton Street
Key West, FL 33040

August 5, 2003

Richard H. Legg
Managing Senior Vice President & Chief Operating Officer
Acordia National
602 Virginia Street, East
P. O. Box 3043
Charleston, WV 25331-3043

Dear Mr. Legg:

It has been several months since we met on the issue of claims being processed incorrectly as to usual and customary and with out-of-date Medicode rates. It was determined very early in the audit that the errors began occurring in late 2000. To estimate the extent of the error, claims have been rerun by your staff using the correct code and applying the usual and customary guidelines. Based on the information of this rerun, there has been an overpayment of $156,534.03. This overpayment is broken down in to the following:

Examiner Error	$82,362.44
Employee Portion	14,686.26
90th Percentile Medicode not updated	52,877.70
Employee Portion	6,607.63
Total	$156,534.03

These claims should be reprocessed immediately. Please advise when this has occurred.

Another issue that has been brought to our attention is our direction to you of June 18, 2001(copy attached). On Proposal 14, we directed you to process claims under Medicare guidelines regarding unbundling of costs. It is our understanding the you are not using these guidelines, but another guide for unbundling costs. Could you please clarify what you are using and how it differs from Medicare.

Attached you will find a copy of the audit produced by the Clerk of the Court. Some areas of the audit are still being reviewed by the internal auditor and a report will have to be made to the board on the process of correcting errors discovered in the audit.

Your prompt reply to this letter will be appreciated.

Sincerely,

James L. Roberts
County Administrator

CC Danny Kolhage, Clerk of the Court

VII. Auditee Responses

COUNTY of MONROE
KEY WEST FLORIDA 33040
(305) 294-4641

County Administrator
1100 Simonton
Key West, FL 33040

MEMORANDUM

Date: Tuesday, April 13, 2004

To: Danny Kolhage
Clerk of the Court

From: James L. Roberts
County Administrator

Subject: Supplement Audit Report of Monroe County Health Benefit Program

The Administrator has reviewed the comments by the Internal Audit Department regarding the Monroe County Health Benefit Program. The following are our comments in reference to the report:

A. Network Providers Paid Incorrectly

The auditors reviewed Referral Analysis reports, Single Provider Payment Listings and Acordia's schedule of overpayments from the May 27, 2003 audit and found additional claim processing errors. The breakdown of the claims in the supplemental audit are as follows:

Dimension Providers	(938 Claims)	$83,997.72
KPHA Providers	(223 Claims)	$3,774.68
Dentists	(2,144 Claims)	$22,685.90
Total		$110,458.30

1. Dimension provider claims paid as referrals

Finding:

Numerous Dimension provider claims were paid as referrals, but the providers are actually participants in the Dimension Network. This was determined by review of the Referral Analysis Report. Providers paid as referrals were paid at the in network rate of 80% or 100%. A laboratory that joined the Dimension Network on January 1, 1999 had claims paid as referrals and the claims should have been paid based on the Dimension Fee Schedule. For example, one procedure code (82784) had a charge of $359.42 and Acordia paid $288.00. The Dimension Fee